MEDICAL HISTORY FORM

Name _____ Date_____ Gender _____

Date of Birth_____Height_____ Weight_____ Spouse_____

Address_____

Home #_____ Cell #_____ Guarantor_____DOB:_____

Employer_____ Insurance Co_____SSN_____

Dentist Name_____Physician Name_____

Email Address _____

Please respond to the following questions regarding your medical health.

1) Date of last physical examination_____

2) Are you being treated for any medical condition?

_____

_____

3) Have you had a serious illness, operation or been hospitalized in the last 5 years?

_____

4) Please list in detail all prescription and non-prescription medications that you are taking(dose and time of day taken):

_____

_____

_____

_____

5) Are you allergic to or had a reaction to any of the following:

Local anesthetics	Yes	No
Penicillin or other antibiotics	Yes	No
Sulpha drugs	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Codeine or other narcotics	Yes	No
Iodine	Yes	No

Other _____

Do you have any other allergies? _____

6) Do you have any of the following:

a.	Diabetes	Yes	No
b.	Insulin treated Diabetes	Yes	No
c.	High blood pressure	Yes	No
d.	Low blood pressure	Yes	No
e.	Cardiovascular disease	Yes	No
f.	Damaged heart valves/Rheumatic Heart Disease	Yes	No
g.	Heart Murmur	Yes	No
h.	Stroke	Yes	No
i.	Shortness of Breath	Yes	No
j.	Swollen ankles	Yes	No
k.	Inborn heart defects	Yes	No
l.	Cardiac pacemaker/Defibrillator	Yes	No
m.	Heart attack	Yes	No
n.	Angina/Chest Pain	Yes	No

o. Asthma Yes No
p. Fainting Spells Yes No
q. Seizures/Epilepsy Yes No
r. Hepatitis/Liver Disease Yes No
s. AIDS or HIV infection Yes No
t. Thyroid disease or problems Yes No
u. Emphysema/Bronchitis/COPD Yes No
v. Arthritis or painful joints Yes No
w. Stomach Ulcer/Reflux/Acidity Yes No
x. Crohn's or Colitis Yes No
y. Kidney Disease Yes No
z. Persistent Swollen Glands Yes No
aa. Mental Health Issues/Psychiatric Care Yes No
bb. Anxiety Disorder/Panic Attacks Yes No
cc. Attention Deficit Disorder Yes No
dd. Depression Yes No
ee. Cancer/Radiation treatment Yes No
ff. Abnormal Bleeding Yes No
gg. Treatment of a tumor or growth Yes No
hh. Osteoporosis/Bisphosphonate medicine Yes No
ii. Sleep Apnea Yes No

7) Do you smoke or use smokeless tobacco Yes No
a) Are you a former tobacco user Yes No
b) How many years have/did you used tobacco? _____
c) How much tobacco do/did you use per day? _____
8) Do you use/drink alcoholic beverages Yes No
a) What type_____
b) How many times per week do you use alcoholic beverages?_____
9) Do you use any illicit street drugs? Yes No
a) What type_____
10) Do you wear contact lenses? Yes No
11) Do you have pain/sounds in your Temporomandibular joints? Yes No

<u>Women</u>

11) Are you pregnant? Yes No
12) Are you nursing? Yes No
13) Are you taking birth control pills? Yes No

I certify that I have read and understand the above questionnaire. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not withhold information regarding my medical health. I will not hold my surgeon/physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of the Patient_____

Signature of Guardian/Parent _____ Relationship_____

To be completed by Surgeon
Medical Management Issues from questionnaire or oral interview

_____

_____

Date_____ Signature of Surgeon_____

Date_____ Signature of Surgeon_____

Date_____ Signature of Surgeon_____